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Office of Administrative Law Judges
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Issue Date: 22 April 2005

Case No. 2004-BLA-5430
2004-BLA-5732

In the Matter of

RUFUS HARVILLE (Deceased),

And

CALLIE HARVILLE, Widow of
RUFUS HARVILLE,
Claimants,

v.

LAUREL RIVER COAL PROCESSING,
Employer,

and

AMERICIAN RESOURCES INS. CO.,
Carrier,

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES:

Monica Rice Smith, Esq., attorney at hearing
Edmond Collett, Esq., attorney of record
Edmond Collett, PSC
Hyden, Kentucky
For the Claimants

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Lexington, Kentucky
For the Employer

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Nashville, Tennessee
For the Director

BEFORE: JOSEPH E. KANE
Administrative Law Judge

DECISION AND ORDER –DENIAL OF MINER'S BENEFITS AND SURVIVOR'S BENEFITS

These cases arise from two claims for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977 (hereinafter the Act), 30 U.S.C. § 901 et seq., and the regulations issued thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.

On December 11, 2003, these cases were referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs for a hearing. (DX 77, 79).[1] A formal hearing in these matters was conducted on February 9, 2005, in London, Kentucky, by the undersigned. All parties were afforded full opportunity to present evidence as provided in the Act and the regulations issued thereunder. The opinion which follows is based on all relevant evidence of record.

ISSUES[2]

The issues in these cases are:

[1] In this Decision and Order, "DX" refers to the Director's exhibits, "EX" refers to the Employer's exhibits, "CX" refers to Claimant's exhibits, "ALJX" refers to the Administrative Law Judge's exhibits, and "TR" refers to the transcript of the hearing.

[2] The Employer stipulated to Mr. Harville being a miner, post-1969 coal mine employment, timeliness, dependency, seven and half years of coal mine employment, and the Employer as the responsible operator in both claims. (TR 9-11). The Employer maintained constitutional issues for appeal purposes. Id.

1. The length of coal mine employment (Miner and Survivor);

2. Whether the Miner had pneumoconiosis as defined in the Act and regulations (Miner and Survivor);

3. Whether the Miner's pneumoconiosis arose out of coal mine employment (Miner and Survivor);

5. Whether the Miner was totally disabled (Miner);

6. Whether the Miner's disability was due to pneumoconiosis (Miner); and,

7. Whether the Miner's death was due to pneumoconiosis (Widow).

(TR 9-11; DX 77, 79).

Based upon a thorough analysis of the entire record in these cases, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural History

The Miner, Rufus Harville, filed his first application for benefits on August 13, 1990. (DX 1). The claim was denied by the Office of Worker's Compensation Programs on January 29, 1991. Id. The parties did not request a formal hearing pursuant to § 725.419(d), and the case was administratively closed. Id. On May 6, 1992, the Claimant filed his second claim for benefits. Id. The District Director denied benefits on October 30, 1992. Id. The case was administratively closed per § 725.419(d).

The Miner's third claim for benefits was filed on July 7, 1994. (DX 1). The District Director again denied benefits on December 7, 1994. Id. The Claimant requested a formal hearing, and Administrative Law Judge Richard E. Huddleston issued a denial of benefits on September 4, 1996. Id. The Miner appealed that Decision to the Benefits Review Board (hereinafter the Board) who affirmed Judge Huddleston's decision on August 19, 1997. Id.

The Miner's current application for benefits was filed on February 6, 2002. (DX 5). The District Director issued a Proposed Decision and Order denying benefits on August 26, 2003. (DX 36). This matter was transferred to this office after the Claimant submitted a request for a formal hearing conducted by an Administrative Law Judge. (DX 37, 77).

Mr. Harville's widow, Callie Harville, filed her claim for benefits on August 12, 2002. (DX 41). The District Director denied benefits on September 30, 2003. (DX 71). On October 9, 2003, the Claimant filed a timely notice requesting a formal hearing. (DX 72). This case was then referred to this office.

Background:

The Miner was born on February 12, 1941, and died on July 5, 2002. (DX 5, 46). He completed a sixth grade education. (DX 5). The Miner married his widow, Callie Harville, on November 5, 1960, and remained married to her until his death. (DX 3; TR 17). In his application for benefits, the Miner claimed nineteen years of coal mine employment. (DX 6).

Mrs. Harville testified at the hearing that the Miner hauled coal from the strip pits and worked outside the truck as well. (TR 17-18). She also explained that he would return home at night after working, covered in black coal dust. (TR 18). Mrs. Harville stated that her husband suffered from shortness of breath, sputum production, and cough. Id. She testified that the Miner became disabled in 1988 after a tumor was removed from the right side of his head and his vision was impaired from a car wreck. (TR 19). After 1988, the Miner began to experience breathing problems, and he was seen by Dr. Parks who prescribed four breathing treatments a day. (TR 20). Mrs. Harville testified that her husband was diagnosed with esophageal cancer around 1999. Id. He underwent radiation and chemotherapy, and eventually surgery in 2000. (TR 21). After that date, he was on oxygen twenty-four hours a day. Mrs. Harville also stated that her husband experienced a heart attack in the 1990s. (TR 22).

Mrs. Harville did not testify as to the Miner's smoking history. Judge Huddleston made a smoking determination of thirty-pack years with the Miner quitting in 1987 or 1988. He based his finding on the Miner's testimony in which he stated that he began smoking at age fifteen or sixteen and smoked a pack to a pack and a half a day. I hereby adopt Judge Huddleston's smoking history and find the Miner had a thirty-pack year smoking history, quitting in 1987 or 1988.

Dependency:

The Miner alleges one dependent, namely his wife, Callie Sizemore, whom he married on November 5, 1960. (DX 3, 5). Mrs. Harville alleges no dependents. (DX 41). Therefore, I find that the Miner has one dependent for purposes of benefit augmentation, and Mrs. Harville has no dependents for the purposes of her benefit argumentation.

Length of Coal Mine Employment:

The Miner alleges approximately nineteen years of coal mine employment in his application for benefits. (DX 5). At the hearing, the Employer and Director stipulated to seven and a half years of coal mine employment. (TR 10). The District Director previously made a finding of seven years. (DX 36, 71). The most probative evidence of record includes the Miner's Social Security earnings report and W-2 forms. (DX 8, 44). Accordingly, I find that Mr. Sizemore was a coal miner, as that term is defined by the Act and Regulations, for a period of seven and a half years. He last worked in the Nation's coal mines in 1988. (DX 1, 44).

Applicable Regulations:

Because these claims were filed after March 31, 1980, the effective date of Part 718, they must be adjudicated under those regulations. Amendments to the Part 718 regulations became effective on January 19, 2001. As these claims were filed on February 6, 2002 and August 12 2002, such amendments are applicable.

The 2001 amendments significantly limit the development of medical evidence in black lung claims. The regulations provide that claimants are limited to submitting no more than two chest x-rays, two pulmonary function tests, two arterial blood gas studies, one autopsy report, one biopsy report of each biopsy, and two medical reports as affirmative proof of their entitlement to benefits under the Act. § 725.414(a)(2)(i). Any chest x-ray interpretations, pulmonary function test results, arterial blood gas study results, autopsy reports, biopsy reports and physician opinions that appear in a single medical report must comply individually with the evidentiary limitations. Id. In rebuttal to evidence propounded by an opposing party, a claimant may introduce no more than one physician's interpretation of each chest x-ray, pulmonary

function test, arterial blood gas study, biopsy or autopsy. § 725.414(a)(2)(ii). Likewise, employers and the District Director are subject to identical limitations on affirmative and rebuttal evidence. § 725.414(a)(3)(i, iii).

Living Miner's Claim

Subsequent Claim:

In cases where a claimant files more than one claim and the earlier claim is denied, the later claim must also be denied on the grounds of the earlier denial unless there has been a material change in condition or the later claim is a request for a modification. Section 725.309(d). The Miner's previous claim was a subsequent claim for benefits which was denied by Judge Huddleston on September 4, 1996 and affirmed by the Board on August 19, 1997. (DX 1). The current claim was filed on February 6, 2002, not within one year of the prior denial, so that it cannot be construed as a modification proceeding pursuant to Section 725.310(a). Therefore, according to Section 725.309(d) this claim must be denied on the basis of the prior denial unless there has been a material change in condition.

Section 725.309(d) provides that a subsequent claim must be denied unless the Claimant demonstrates that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final. The applicable conditions of entitlement are limited to those conditions upon which the prior denial was based. §725.309(d)(2). If the Claimant establishes the existence of one of these conditions, he has demonstrated, as a matter of law, a material change. If he is successful in establishing a material change, then all of the record evidence must be reviewed to determine whether he is entitled to benefits.

The previous claim was denied when it was determined that the Miner did not establish a change in condition after failing to prove the existence of pneumoconiosis, causation, total disability, or total disability due to pneumoconiosis. (DX 1). Accordingly, the newly submitted medical evidence will be reviewed in order to determine whether there has been a material change in condition.

Pneumoconiosis:

Section 718.202(a) sets forth four alternate methods for determining the existence of pneumoconiosis. Pursuant to Section 718.202, the miner can demonstrate pneumoconiosis by means of 1) x-rays interpreted as positive for the disease, or 2) biopsy or autopsy evidence, or 3) the presumptions described in Sections 718.304, 718.305, or 718.306, if found to be applicable, or 4) a reasoned medical opinion which concludes the presence of the disease, if the opinion is based on objective medical evidence such as pulmonary function studies, arterial blood gas tests, physical examinations, and medical and work histories.

Under Section 718.202(a)(1), a finding of the presence of pneumoconiosis may be based upon a chest x-ray conducted and classified in accordance with Section 718.102. To establish the existence of pneumoconiosis, a chest x-ray must be classified as category 1, 2, 3, A, B, or C, according to the ILO-U/C classification system. A chest x-ray classified as category 0, including subcategories 0/1, 0/0, or 0/-, does not constitute evidence of pneumoconiosis.

The newly submitted evidence contains three x-rays. The Miner offered the x-ray of Dr. Vaezy dated August 11, 1994. (DX 14). However, this x-ray was considered by Judge Huddleston in the Miner's prior claim. Thus, it offers no value in determining if the Miner can establish a material change in condition, and accordingly, I afford it little weight.

Dr. Simpao, who has no radiological qualifications, interpreted a March 25, 2002 x-ray as positive for pneumoconiosis with a 1/1 profusion. (DX 11). He also noted an abnormality of the cardiac size of shape, an ill-defined diaphragm, and an ill-defined heart outline. The remainder of his notes are illegible. Additionally, Dr. Sargent re-read the x-ray, making no determinations with respect to pneumoconiosis. Id. However, he did record abnormality of the cardiac size of shape, pleural effusion left base, cardiomegaly, and previous CHBG procedure. The remainder of his notes are illegible as well. Dr. Sargent is a Board-certified radiologist and B-reader.[3]

[3] A B-reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the United States Department of Health and Human Services. 42 C.F.R. § 37.51. The qualifications of physicians

Also, the x-ray was interpreted as negative by Dr. Spitz, a Board-certified radiologist and B-reader. (EX 1). However, Dr. Spitz did note a portocath, coronary bypass, possible esophageal resection with gastric pull through, and bilateral pleural disease. In addition, Dr. Wiot read the x-ray as negative for pneumoconiosis.[4] (DX 16, 67). Dr. Wiot listed a pericardial effusion, abnormality of cardiac size, and previous surgery. Dr. Wiot is a Board-certified radiologist and B-reader.

Dr. Alexander interpreted a February 2, 2002 x-ray as positive for pneumoconiosis with a 2/3 profusion. (CX 1-2). He also noted an ill-defined diaphragm, pleural thickening possibly related to prior surgery, post surgical changes in the right mediastinum with partial resection of the sixth rib, prior CABG surgery, bilateral chest wall, and coalescence of small pneumoconiotic opacities. Dr. Alexander is a Board-certified radiologist and B-reader. In addition, Dr. Spitz, a B-reader and Board-certified radiologist, re-read the x-ray as negative for pneumoconiosis. (EX 2). He listed coronary bypass, surgical removal of the right sixth rib, pleural thickening at the right lateral chest wall and left base, and possible esophageal resection with gastric pull through. Furthermore, Dr. Wiot reviewed the x-ray.[5] (DX 17, 67). He found the x-ray negative for pneumoconiosis, but indicated effusions, portocath, and previous surgery. As noted above, Dr. Wiot is a Board-certified radiologist and B-reader.

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are a matter of public record at the National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. Because B-readers are deemed to have more training and greater expertise in the area of x-ray interpretation for pneumoconiosis, their findings may be given more weight than those of other physicians. Taylor v. Director, OWCP, 9 BLR 1-22 (1986).

[4] At the hearing, Employer's counsel stated that he wished Dr. Wiot's interpretation of the March 25, 2002 x-ray to count as initial evidence per § 725.414(a)(3)(i). (TR 13). As such, I will consider it accordingly.

[5] At the hearing, Employer's counsel stated that he wished Dr. Wiot's interpretation of the February 2, 2002 x-ray to count as initial evidence per § 725.414(a)(3)(i). (TR 13). As such, I will consider it accordingly.

Also, treatment notes from the Heart Doctors in London, Kentucky were offered. (DX 49). These notes included several x-ray readings; however, none were performed on the Department sponsored ILO forms. Moreover, they were not taken for the purpose of diagnosing pneumoconiosis. Accordingly, I grant the x-rays contained in the treatment notes from the Heart Doctors less weight.

Upon careful review of the x-ray evidence of record, I find that the preponderance of negative readings by B-readers and board-certified radiologists outweigh the positive x-ray interpretations of record. Under Part 718, where the x-ray evidence is in conflict, consideration shall be given to the readers' radiological qualifications. Dixon v. North Camp Coal Co., 8 BLR 1-344 (1985). Thus, it is within the discretion of the administrative law judge to assign weight to x-ray interpretations based on the readers' qualifications. Goss v. Eastern Associated Coal Co., 7 BLR 1-400 (1984). Accordingly, great weight may be assigned to an x-ray interpretation of a B-reader. Aimone v. Morrison Knudson Co., 8 BLR 1-32 (1985). In addition, even greater weight may be assigned to an x-ray interpretation of a board-certified radiologist. Roberts v. Bethlehem Mines Corp., 8 BLR 1-211, 1-213 n. 5 (1985). In this case, Dr. Simpao, who has no radiological qualifications, interpreted an x-ray as positive. However, this x-ray was also read as negative by a B-reader and Board-certified radiologist. Conversely, Dr. Alexander, a Board-certified radiologist and B-reader, interpreted an x-ray as positive for pneumoconiosis, but two Board-certified radiologists and B-readers re-read the x-ray as negative. Thus, one physician who is a Board-certified radiologist and B-reader re-read a positive x-rays as negative, and additionally another x-ray stands in equipoise as it was interpreted as both negative and positive by the highest qualified readers.

The record also contains more negative interpretations than positive. It is within the discretion of the administrative law judge to defer to the numerical superiority of the x-ray interpretations. Edmiston v. F & R Coal Co., 14 BLR 1-65 (1990). The United States Court of Appeals for the Sixth Circuit has confirmed that consideration of the numerical superiority of the x-ray interpretations, when examined in conjunction with the readers' qualifications, is a proper method of weighing x-ray evidence. Stanton v. Norfolk & Western Railway Co., 65 F.3d 55 (6th Cir. 1995) (citing Woodward v. Director, OWCP, 991 F.2d 314 (6th Cir. 1993)).

The record consists of two positive interpretations of the March 25, 2002 and February 2, 2002 x-rays. (DX 11; CX 1). By contrast, the evidence contains four negative interpretations of the same x-rays. (DX 16-17, 67; EX 1-2) Accordingly, I rely on the preponderance of negative readings in finding that the Claimant has failed to establish the existence of pneumoconiosis pursuant to Section 718.202(a)(1).

A claimant may establish the existence of pneumoconiosis by biopsy or autopsy evidence pursuant to Section 718.202(a)(2). As no biopsy or autopsy evidence exists in the record, this section is inapplicable in this case.

Section 718.202(a)(3) provides that it shall be presumed that the miner is suffering from pneumoconiosis if the presumptions described in Sections 718.304, 718.305, or 718.306 are applicable. Section 718.304 is not applicable in this case because there is no evidence of complicated pneumoconiosis. Section 718.305 does not apply because it pertains only to claims that were filed before January 1, 1982. Finally, Section 718.306 is not relevant because it is only applicable to claims of miners who died on or before March 1, 1978.

The fourth and final way to establish the existence of pneumoconiosis is set forth in Section 718.202(a)(4). This subsection provides for such a finding where a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis. Any such finding shall be based upon objective medical evidence and shall be supported by a reasoned medical opinion. A reasoned medical opinion is one which contains underlying documentation adequate to support the physician's conclusions. Field v. Island Creek Coal Co., 10 BLR 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts and other data on which he bases his diagnosis. Id.

Three physicians' medical reports, two sets of treatment records, and a death certificate were introduced as newly submitted evidence. The Miner offered the report of Dr. Vaezy dated August 11, 1994. (DX 14). However, this medical report was considered by Judge Huddleston in the Miner's prior claim. Thus, it offers no value in determining if the Miner can establish a material change in condition, and accordingly, I afford it little weight.

Dr. Simpao, Board-certified in Internal Medicine and Pulmonary Disease, conducted a physical examination on March 25, 2002. (DX 11; CX 3). He also performed a chest x-ray, pulmonary function test, and arterial blood gas study. He recorded that the Miner performed coal mine work for twenty years. He also noted a smoking history of forty-three pack-years with the Miner quitting in 2000. His report stated that the Miner suffered from daily cough (8 years), daily sputum production of two to three tablespoons (8 years), wheezing at rest and exertion (8 years), dyspnea at rest and exertion (8 years), occasional hemoptysis, chest pains (8 years), ankle edema, and paroxysmal nocturnal dyspnea (8 years). A chest examination revealed "few crepitations," "tactile fremitus increased right over left," and "increased resonance upper chest and axillary areas." An EKG was normal. Dr. Simpao diagnosed pneumoconiosis, based on a history of dust exposure, a positive x-ray finding, a pulmonary function test, arterial blood gas analysis, physical findings, and symptomatology. He further opined that the Miner suffers from a severe, totally disabling impairment due to pneumoconiosis. He also stated that the Miner is not able to perform the work of a coal miner or to perform comparable work in a dust free environment.

A supplemental report from Dr. Simpao dated August 23, 2003 was offered into evidence. (DX 33). He reiterated his finding set forth above, and also stated that even if the Miner's employment history was seven years that was still sufficient to influence his pulmonary condition. Dr. Simpao opined that the Miner's respiratory impairment was due to his coal dust exposure and long smoking history. He also noted that the Miner's cancer treatments made him more susceptible to disease progression. He concluded by maintaining that the Claimant has coal workers' pneumoconiosis.

On February 2, 2002, Dr. Baker, Board-certified in Internal Medicine and Pulmonary Diseases, performed a physical exam of the Claimant. (DX 15). He also conducted various diagnostic tests including a chest x-ray, a pulmonary function test, and an arterial blood gas analysis. He recorded that the Miner worked approximately twenty years in coal mine employment. He noted the Miner had a twenty pack-year smoking history, quitting in 1995. Dr. Baker stated that the Miner has breathing difficulties, with variable symptoms of daily cough, daily sputum production, daily wheezing, and dyspnea. He also noted that the Miner's breathing was aggravated by cold air, dusts, odors, and fumes. Dr. Baker's chest examination revealed "diminished breath sounds bilaterly."

Dr. Baker made the following diagnosis: 1) moderate restrictive ventilatory defect - based on pulmonary function studies; 2) moderate resting arterial hypoxemia – based on arterial blood gas analysis; 3) chronic bronchitis - based on history of symptoms; and 4) ischemic heart disease based on history and physical examination. (DX 15). Furthermore, Dr. Baker noted that the Miner has a Class 4 impairment according to Guides to the Evaluation of Permanent Impairment, Fifth Edition. This is based on the Miner's forced vital capacity being 49% of the predicted value. Additionally, Dr. Baker stated the Miner had long smoking and coal dust exposure histories, and that his impairment was to some extent related to coal dust.

In his deposition taken on March 27, 2003, Dr. Baker testified that even if the Miner had a smoking history of thirty-five years, his report would remain unchanged. (DX 30, 66). Dr. Baker stated that the Miner did not have coal workers' pneumoconiosis and, even if he did, then the disease did not cause or hasten his death. As to the Miner's impairment, Dr. Baker said it was secondary to a long smoking history and post operative changes from bypass surgery and esophageal surgery. He was able to make these determinations based on a restrictive defect which is usually a chest wall or fibrosis problem, arterial blood gas analysis, and a negative x-ray. Dr. Baker stated that the Miner is "fairly much disabled" due to his respiratory impairment and other diseases, but coal workers' pneumoconiosis did not cause the impairment.

The Miner's death certificate was introduced into evidence. (DX 18, 45-46). Dr. Rock signed the certificate after the Miner's death on July 5, 2002. The listed cause of death was esophageal cancer. Also noted, in the section titled "other significant conditions that contributed to death but not resulting in the underlying cause" included black lung, coronary artery disease, type II diabetes mellitus.

Additionally, Dr. Rock's treatment notes were included in the evidence of record. (DX 48). Dr. Rock was the Miner's treating physician from December 30, 1996 until his death. His examinations during that time period included notations of diminished breath sounds, wheezing, and pleural effusion. He also prescribed oxygen for the Miner's breathing problems and listed that he suffered from chronic obstructive pulmonary disease. However, the majority of Dr. Rock's treatment notes relate to the Miner's esophageal cancer.

In his January 14, 2003 deposition, Dr. Rock testified that he believed the Miner had black lung although it was not recorded in his treatment notes. (DX 51). He stated that he had listed it on the Miner's death certificate but that the disease did not accelerate or hasten the Miner's death. Dr. Rock explained that he noted the disease on the Miner's death certificate because of the Miner's employment history in coal mines, and he felt that part of the Miner's chronic obstructive pulmonary disease was secondary to black lung and smoking.

The treatment notes from The Heart Doctors in London, Kentucky that date from January 27, 1999 to June 26, 2002 were offered into evidence. (DX 49). These notes include numerous x-rays, several echocardiography reports, a CT scan, and a pulmonary function study and an arterial blood gas analysis that do not meet Regulation standards. In letters dated August 31, 2000 and April 26, 2001, Dr. Mandviwala listed chronic obstructive pulmonary disease with chronic hypoxemia based on arterial blood gas analysis, x-ray, exam and pulmonary function study. Also, he noted "with regards to persistent hypoxemia, the pulmonary function test does suggest significant airflow obstruction which suspect is related to tobacco abuse." Although emphysema and fibrosis are mentioned in the treatment notes, the majority of the records relate to the Miner's treatment involving his esophageal cancer.

In the newly submitted evidence, only two physicians diagnose clinical pneumoconiosis, Drs. Simpao and Rock. Dr. Rock listed black lung on the Miner's death certificate and testified at his deposition he believed the Miner suffered from the disease. However, his treatment notes were devoid of such a notation. The Board has held that it is proper to accord little probative value to a physician's opinion which is inconsistent with his or her earlier report or testimony. Hopton v. U.S. Steel Corp., 7 B.L.R. 1-12 (1984). As Dr. Rock's treatment notes are inconsistent with his testimony and the Miner's death certificate, I afford his opinions, in the previously mentioned evidence of record, less weight. Moreover, Dr. Rock's opinion regarding clinical pneumoconiosis is neither well-reasoned nor well-documented. A reasoned medical opinion is one which contains underlying documentation adequate to support the physician's conclusions. Field v. Island Creek Coal Co., 10 BLR 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts and other data on which he bases his diagnosis. Id. Dr. Rock failed to cite to any objective medical testing or data that was supportive of his finding of clinical pneumoconiosis. Also, he

did not clearly explain how his physical findings on examination led to his diagnosis of black lung. Therefore, I also find his opinion, regarding clinical pneumoconiosis, is not well-reasoned or well-documented.

Moreover, the Board has held that an administrative law judge can properly discredit a physician's opinion based upon an x-ray study that was later interpreted as negative for the existence of the disease by a B-reader. See Armoni v. Director, OWCP, 6 B.L.R. 1-423. Dr. Simpao relied upon an x-ray that he interpreted as positive; however, the x-ray was subsequently read by Drs. Wiot and Spitz as negative. Both Drs. Wiot and Spitz are B-readers and Board-certified radiologists. Accordingly, I grant less weight to Dr. Simpao's determination of pneumoconiosis.

Pursuant to Section 718.201(a)(2), "legal pneumoconiosis" includes any chronic lung disease or impairment arising out of coal mine employment. This definition includes any chronic restrictive or obstructive pulmonary disease. Dr. Baker diagnosed the Claimant with moderate restrictive ventilatory defect, moderate resting arterial hypoxemia, and chronic bronchitis. (DX 15). However, Dr. Baker noted that the Miner's diseases were not a result of coal dust exposure. Thus, his determinations do not qualify as legal pneumoconiosis. Moreover, Dr. Mandviwala in the treatment notes from The Heart Doctors opined the Miner had chronic obstructive pulmonary disease with chronic hypoxemia. (DX 49). He expressly stated that the persistent hypoxemia was a result of the Miner's smoking history. He failed to give an etiology for the Miner's chronic obstructive pulmonary disease. Therefore, neither of Dr. Mandviwala's findings qualify as legal pneumoconiosis. Also, Dr. Rock opined that the Miner had chronic obstructive pulmonary disease. (DX 48). Although he did not indicate an etiology for the disease in his treatment notes, he testified, at his deposition, that the Miner's chronic obstructive pulmonary disease was secondary to his black lung and smoking histories. (DX 51). Assuming that Dr. Rock's diagnosis constitutes legal pneumoconiosis, it is not well-reasoned or well-documented. Dr. Rock failed to cite to any objective medical testing or data that was supportive of his determination. Also, he did not clearly explain how his physical findings and the Miner's symptomatoloy supported his opinion. Thus, Dr. Rock's opinions regarding both clinical and legal pneumoconiosis are neither well-reasoned nor well-documented.

Accordingly, with respect to pneumoconiosis, I rely on the well-reasoned and well-documented report of Dr. Baker. I find that the Miner has not established the existence of pneumoconiosis. As such, he has not proven a material change in condition. Because the existence of pneumoconiosis is the threshold issue in any claim for black lung benefits under the Act, entitlement to benefits under the Act is not established.

Arising Out of Coal Mine Employment:

Next, the Miner must establish that his pneumoconiosis arose, at least in part out of coal mine employment. See § 718.203(a). A miner with less than ten years of coal mine employment bears the burden of proving the causal relationship between pneumoconiosis and the coal mine employment. 20 C.F.R. § 410.416(b); Fly v. Peabody Coal Co., 1 B.L.R. 1-713 (1978). In this case, the Miner had a coal mine employment history of seven and half years; therefore, he must carry the burden of proving the causal relationship. I continue to rely on my above-noted findings. As the Miner has failed to prove pneumoconiosis, he is unable to establish pneumoconiosis arose out of his coal mine employment or a material change in condition.

Total Disability:

Total disability is defined as the miner's inability, due to a pulmonary or respiratory impairment, to perform his usual coal mine work or engage in comparable gainful work in the immediate area of the miner's residence. § 718.204(b). Total disability can be established pursuant to one of the four standards in Section 718.204(b)(2) or the irrebuttable presumption of Section 718.304, which is incorporated into Section 718.204(b). The presumption is not invoked here because there is no x-ray evidence of large opacities classified as category A, B, or C, and no biopsy or equivalent evidence.

Where the presumption does not apply, a miner shall be considered totally disabled if he meets the criteria set forth in Section 718.204(b)(2), in the absence of contrary probative evidence. The Board has held that under Section 718.204(c), the precursor to § 718.204(b)(2), that all relevant probative evidence, both like and unlike, must be weighed together, regardless of the category or type, to determine whether a miner is totally disabled. Shedlock v. Bethlehem Mines Corp., 9 BLR 1-195, 1-198 (1986); Rafferty v. Jones & Laughlin Steel Corp., 9 BLR 1-231, 1-232 (1987). Furthermore, the Claimant must

establish this element by a preponderance of the evidence. Gee v. W.G. Moore & Sons, 9 BLR 1-4, 1-6 (1986).

Subsection (b)(2)(i) of § 718.204 provides for a finding of total disability where pulmonary function tests demonstrate FEV_1[6] values less than or equal to the values specified in the Appendix to Part 718 and such tests reveal FVC[7] or MVV[8] values equal to or less than the applicable table values. Alternatively, a qualifying FEV_1 reading together with an FEV_1/FVC ratio of 55% or less may be sufficient to prove disabling respiratory impairment under this subsection of the regulations. § 718.204(b)(2) and Appendix B. The newly submitted evidence of record consists of three pulmonary function studies.[9] (DX 11, 14-15). The study conducted Dr. Vaezy, dated August 11, 1994, was considered by Judge Huddleston in the Miner's prior claim. Thus, it offers no value in determining if the Miner can establish a material change in condition, and accordingly, I afford it little weight. (DX 14). Dr. Younes found the March 25, 2002 pulmonary function study to be of acceptable quality. (DX 12). That study along with the February 2, 2002 study produced qualifying values indicative of total disability. (DX 11, 15). Thus, I find the pulmonary function study evidence of record establishes total disability under subsection (b)(2)(i).

Section 718.204(b)(2)(ii) provides for the establishment of total disability through the results of arterial blood gas tests. Blood gas tests may establish total disability where the results demonstrate a disproportionate ratio of pCO2 to pO2, which indicates the presence of a totally disabling impairment in the transfer of oxygen from the Claimant's lung alveoli to his blood. § 718.204(c)(2) and Appendix C. The test results must meet or fall below the table values set forth in Appendix C following Section 718 of the regulations. Three studies have

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[6] Forced expiratory volume in one second.

[7] Forced vital capacity.

[8] Maximum voluntary ventilation.

[9] The treatment records from The Heart Doctors included a pulmonary function study. However, the study did not include three tracings as required by the Regulations, so it will not be considered herein. See Section 718.103(b); Estes v. Director, OWCP, 7 BLR 1-414 (1986).

been entered into the record.[10] (DX 11, 14-15). The analysis conducted Dr. Vaezy, dated August 11, 1994, was considered by Judge Huddleston in the Miner's prior claim. Thus, it offers no value in determining if the Miner can establish a material change in condition, and accordingly, I afford it little weight. (DX 14). The study dated February 2, 2002 is non-qualifying pursuant to Section 718.105(c)(2). (DX 15). The study conducted by Dr. Simpao produced non-qualifying values under the regulatory standards for disability. (DX 11). Therefore, I find that the blood gas study evidence of record fails to establish total disability under subsection (b)(2)(ii).

Total disability under Section 718.204(b)(2)(iii) is inapplicable because the Claimant failed to present evidence of cor pulmonale with right-sided congestive heart failure.

Finally, the Claimant establishes total disability under Section 718.204(b)(2)(iv). Where total disability cannot be established under subparagraphs (b)(2)(i), (b)(2)(ii) or (b)(2)(iii), Section 718.204(b)(2)(iv) provides that total disability may nevertheless be found if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents the miner from engaging in his usual coal mine work or comparable gainful work.

The treatment notes from Dr. Rock and The Heart Doctors do not contain physicians' opinions regarding total disability. (DX 48-49, 51). Thus, these treatment notes will not be considered in this section of my Decision and Order.

I continue to afford the report of Dr. Vaezy, dated August 11, 1994, less weight as it was considered by Judge Huddleston in the Miner's prior claim. As such, it offers no value in determining if the Miner can establish a material change in condition.

Only two physicians in the newly submitted evidence made total disability findings.[11] (DX 11, 15). Dr. Simpao diagnosed

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[10] The treatment records from The Heart Doctors included an arterial blood gas analysis. However, the study did not meet the standards set forth by the Regulations, so it will not be considered herein. See § 718.105(c)(2).

[11] A medical opinion does not have to be wholly reliable or wholly unreliable, rather the opinion can be divided into the

the Claimant with a mild respiratory impairment due to pneumoconiosis. (DX 11). He also stated the Claimant does not retain the pulmonary capacity to perform his prior coal mine work. Dr. Simpao noted that he relied on a positive chest x-ray, a qualifying pulmonary function test, arterial blood gas analysis, symptomatology, and physical findings.

From his own examination, Dr. Baker determined that the Claimant had a Class 4 impairment based on Guides to the Evaluation of Permanent Impairment, Fifth Edition. This is based on the Miner's forced vital capacity being 49% of the predicted value. Additionally, Dr. Baker stated the Miner had long smoking and coal dust exposure histories, and that his impairment was to some extent related to coal dust. He failed to opine if the Claimant was totally disabled in his medical report. In his deposition, Dr. Baker stated that the Claimant was "fairly much disabled" due to a respiratory impairment and other diseases.

The Board and United States Sixth Circuit Court of Appeals, under whose jurisdiction this case arises, have held that it is proper for an administrative law judge to grant less weight to an opinion that is equivocal or vague. See Island Creek Coal Co. v. Holdman, 202 F.3d 873(6th Cir. 2000); Parsons v. Black Diamond Coal Co., 7 B.L.R. 1-236 (1984). Dr. Baker's opinion that the Miner was "fairly much disabled" is vague and does not clearly express if he made a finding of total disability. Therefore, I grant his opinion regarding total disability less weight.

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relevant issues of entitlement to determine whether it is reasoned and documented with regard to any particular issue. See Drummond Coal Co. v. Freeman, 17 F.3d 361 (11th Cir. 1994); Billings v. Harlan #4 Coal Co., B.R.B. No. 94-3721 BLA (June 19, 1997) (en banc) (unpub.). Accordingly, I divide Drs. Simpao's and Baker's opinions into the relevant issues of pneumoconiosis and total disability. As noted supra with respect to pneumoconiosis, Dr. Baker's report is well-reasoned and well-documented. However, in examining the second issue of total disability, Dr. Baker's is afforded less weight. Also, Dr. Simpao's finding of pneumoconiosis was found to be neither well-reasoned nor well-documented. However, his total disability determination is supported by objective medical testing, and thus, this part of his report is well-reasoned and well-documented.

I rely on Dr. Simpao's report, the only well-reasoned and well-documented newly submitted opinion of record, to find the Miner has established total disability pursuant to Section 718.204(b)(2)(iv). In reviewing the all of the newly submitted evidence, I acknowledge the arterial blood gas analysis was not supportive of total disability, but I rely on the qualifying pulmonary function studies and the well-reasoned and well-documented medical report of Dr. Simpao. I find the Miner has established total disability per Section 718.204(b)(2). As such, the Miner has established a material change in condition and the entire record must be examined.

The Miner has three previously filed claims. (DX 1-2). The medical evidence in these claims dates prior to August 1994. The Board has held that it is proper to afford the results of recent medical testing more weight over earlier testing. See Stanford v. Director, OWCP, 7 B.L.R. 1-541 (granting greater weight to a more recent x-ray); Coleman v. Ramey Coal Co., 18 B.L.R. 1-17 (1993) (granting greater weight to a more recent pulmonary function study); Schretroma v. Director, OWCP, 18 B.L.R. (1993) (granting greater weight to a more recent arterial blood gas analysis); Gillespie v. Badger Coal Co., 7 B.L.R. 1-839 (1985) (granting greater weight to a more recent medical report). As the medical evidence in the Miner's previous claims is over ten years old, I grant greater weight to the newly submitted evidence. Accordingly, I continue to rely on the newly submitted evidence to find that the Miner has not established pneumoconiosis and causation but has proven total disability.

Total Disability Due to Pneumoconiosis:

Assuming, arguendo, that the Claimant had established pneumoconiosis and total disability, the Claimant is nonetheless ineligible for benefits because he fails to show total disability due to pneumoconiosis as demonstrated by documented and reasoned medical reports. See § 718.204(c)(2). In interpreting this requirement, the Sixth Circuit has stated that pneumoconiosis must be more than a de minimus or infinitesimal contribution to the miner's total disability. Peabody Coal Co. v. Smith, 127 F.3d 504, 506-507 (6th Cir. 1997). No medical report of record in its entirety is well-reasoned and well-documented. Therefore, I find that the Claimant has failed to establish total disability due to pneumoconiosis.

Survivor's Claim

Section 718.205 provides that benefits are available to eligible survivors of a miner whose death was due to pneumoconiosis. In order to receive benefits, the Claimant must prove that:

1. The Miner had pneumoconiosis;

2. The Miner's pneumoconiosis arose out of coal mine employment; and,

3. The Miner's death was due to pneumoconiosis as provided by this section.

Section 718.205(a).

In order to establish that a Miner's death was due to pneumoconiosis, the Claimant must establish at least one of the following criteria:

1. Where competent medical evidence establishes that the miner's death was due to pneumoconiosis; or

2. Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death, or where death was caused by complications of pneumoconiosis; or

3. Where the presumptions set forth in Section 718.304 regarding complicated pneumoconiosis is applicable.

Section 718.205(c).

Because the record contains no evidence of complicated pneumoconiosis, subsection (c)(3) is inapplicable. Thus, the Claimant will recover if she can prove that the Miner died from pneumoconiosis or that pneumoconiosis substantially contributed to his death. The amended regulations provide that pneumoconiosis is a "substantially contributing cause" of a miner's death if it hastens the miner's death. Section 718.205(c)(5). Thus, the Claimant must prove the pneumoconiosis was the cause of Mr. Harville's death or that it hastened his death. As the Miner was unable to establish pneumoconiosis and causation in his claim, I take judicial notice of those findings

and incorporate them into Mrs. Harville's claim.[12] Therefore, only death due to pneumoconiosis will be addressed.

Death Due to Pneumoconiosis:

Pursuant to § 718.205(c), the Claimant must establish that the Miner's death was due to pneumoconiosis. The United States Court of Appeals for the Sixth Circuit has held that any condition that hastens death is a substantially contributing cause of death for purposes of § 718.205. Brown v. Rock Creek Mining Corp., 996 F.2d 812 (6th Cir. 1993); Griffith v. Director, OWCP, 49 F.3d 184 (6th Cir. 1995).

The only evidence of record that addresses the Miner's cause of death is his death certificate and the deposition testimony of Drs. Rock and Baker. (DX 18, 30, 45-46, 51, 66). Dr. Rock signed the death certificate after the Miner's death on July 5, 2002. The listed cause of death was esophageal cancer. Also noted, in the section titled "other significant conditions that contributed to death but not resulting in the underlying cause" included black lung, coronary artery disease, type II diabetes mellitus.

A death certificate, in and of itself, is an unreliable report of the miner's condition, and it is error for an administrative law judge to accept conclusions contained in such a certificate where the record provides no indication that the individual signing the death certificate possessed any relevant qualifications or personal knowledge of the miner from which to assess the cause of death. Smith v. Camco Mining, Inc., 13 B.L.R. 1-17 (1989); Addison v. Director, OWCP, 11 B.L.R. 1-68 (1988). However, the Board has held that a physician's opinion expressed on a death certificate in addition to his testimony is sufficient to establish the cause of the miner's death. Dillon v. Peabody Coal Co., 11 B.L.R. 1-113 (1998). The Miner's death certificate was signed by his treating physician, Dr. Rock. (DX 18, 45-46). Dr. Rock testified that he believed the Miner had black lung although it was not recorded in his treatment notes. (DX 51). He stated that he had listed it on the Miner's death certificate but that the disease did not accelerate or hasten the Miner's death.

The Board has held that it is proper to accord little probative value to a physician's opinion which is inconsistent

[12] The parties stipulated to the same evidence for the Miner's and Survivor's claims. (ALJX 1-2; TR 13).

with his or her earlier report or testimony. Hopton v. U.S. Steel Corp., 7 B.L.R. 1-12 (1984). As Dr. Rock's testimony, stating that black lung did not accelerate or hasten the Miner's death, is inconsistent with the Miner's death certificate, listing black lung as a contributing condition to the Miner's death, I afford his opinions and the death certificate less weight.

In his deposition taken on March 27, 2003, Dr. Baker testified that the Miner did not have coal workers' pneumoconiosis and even if he did, then the disease did not cause or hasten his death. (DX 30). His diagnostic testing included a negative x-ray, a qualifying pulmonary function test, and non-qualifying arterial blood gas analysis.

Upon reviewing the medical evidence, I do not find it sufficient to establish that the Miner's death was caused by, contributed to, or in any way hastened by simple coal worker's pneumoconiosis. Accordingly, death due to pneumoconiosis has not been established pursuant to § 718.205(c).

Entitlement:

As the Claimant, Callie Harville, has failed to establish the Miner had pneumoconiosis, causation, and pneumoconiosis was a substantially contributing cause or factor leading to the Miner's death or that death was caused by complications of pneumoconiosis, she is not entitled to benefits under the Act.

As the Claimant, Rufus Harville, has established total disability, he proved a material change in condition. However, he failed to establish pneumoconiosis, causation, and total disability arising out of pneumoconiosis after a review of the entire record. I therefore find that he is not entitled to benefits under the Act.

Attorney's Fees:

The award of an attorney's fee under the Act is permitted only in cases in which the Claimant is found to be entitled to the receipt of benefits. Because benefits are not awarded in these cases, the Act prohibits the charging of any attorney's fees to the Claimants for legal services rendered in pursuit of benefits.

ORDER

It is thereby ORDERED that the claim of RUFUS HARVILLE for benefits is hereby DENIED. It is further ORDERED that the claim of CALLIE HARVILLE for survivor's benefits is DENIED.

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JOSEPH E. KANE
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this decision, by filing a notice of appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, D.C. 20210.